Barking Cat Studio ARTcamP
Camper Registration

How did you hear of us? Check all that apply.

- ☐ Current Student
- ☐ Past Student
- ☐ Nabe/Walking by
- ☐ Greenwood Playground
- ☐ Park Slope Parents
- ☐ Mommy Poppins
- ☐ A Child Grows
- ☐ Friend/Referred by _____
- ☐ Google Search
- ☐ Facebook/Instagram
- ☐ Other (please specify)

Date _____

Camper's Name (First) _____ (last) _____ Kid T-Shirt Size ☐ S ☐ M ☐ L ☐ XL

Camper's Birth Date _____ Camper's Grade in September _____ Camper's Preferred Pronoun: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other

SUMMER CAMP 2024 WEEKLY THEMES

Please select desired camp weeks and early drop-off and extended day options below.
Camp fees: $35 non-refundable Registration Fee + $635 per week, EXCEPT week 7 is $675 and includes digital video camera.
Camp hours: 9:00 am – 3:00 pm. Early drop-off: 8 am – 8:45 am is $25 per day. Extended day is $250 for 4 days scheduled in advance or $65 single day Mon-Thurs 3 pm – 5 pm.
NO EXTENDED DAY ON FRIDAY.

☐ Week 1: July 8 – July 12	Mixed Media, Drawing, Painting	Age 5–8	☐ Early Drop-Off: 8:00 – 8:45am	☐ Extended Day: 3:00 – 5:00pm SOLD OUT
☐ Week 2: July 15 – July 19	Mixed Media, Drawing, Painting	Age 9–12	☐ Early Drop-Off: 8:00 – 8:45am	☐ Extended Day: 3:00 – 5:00pm SOLD OUT
☐ Week 3: July 22 – July 26	Clay & Sculpture	Age 5–8	☐ Early Drop-Off: 8:00 – 8:45am	☐ Extended Day: 3:00 – 5:00pm SOLD OUT
☐ Week 4: July 29 – August 2	Clay & Sculpture	Age 9–12	☐ Early Drop-Off: 8:00 – 8:45am	☐ Extended Day: 3:00 – 5:00pm SOLD OUT
☐ Week 5: August 5 – August 9	Harry Potter: Wizard Week	Ages 7+	☐ Early Drop-Off: 8:00 – 8:45am	☐ Extended Day: 3:00 – 5:00pm SOLD OUT
☐ Week 6: August 12 – August 16	Story Makers: Comic Book & Character Design	Ages 9–12	☐ Early Drop-Off: 8:00 – 8:45am	☐ Extended Day: 3:00 – 5:00pm SOLD OUT
☐ Week 7: August 19 – August 23	Lights! Camera! Action! Photo & Video	Age 5–8	☐ Early Drop-Off: 8:00 – 8:45am	☐ Extended Day: 3:00 – 5:00pm SOLD OUT
☐ Week 8: August 26 – August 30	Painting, Printmaking & Collagé	Ages 5+	☐ Early Drop-Off: 8:00 – 8:45am	☐ Extended Day: 3:00 – 5:00pm

FEES, DEPOSITS, PAYMENTS & POLICIES

DEPOSITS/PAYMENTS: $35 non-refundable registration fee plus 50% non-refundable camp tuition deposit or payment in full are due at the time of registration. Balance is due April 1. Registration on or after April 1, requires payment in-full at the time of registration. Barking Cat Studio will NOT prorate for missed days or partial attendance. We accept cash, check, venmo and credit cards.

CANCELLATION POLICY: If cancelling prior to April 15, tuition will be returned minus $35 registration fee + 50% non-refundable deposit. After April 15 the remaining tuition is refundable at the sole discretion of Barking Cat Studio, Inc.

FEE CALCULATOR:

_____ Weeks x $635 (Weeks 1 thru 6 and 8)
_____ Week 7 x $675 (includes digital camera) } = _____ Ⓐ

_____ Early Drop Off Days x $25 per day (M-F) = _____ Ⓑ

_____ Extended Day Week/Monday-Thursday x $250

_____ Single Extended Day x $65 = _____ Ⓒ

_____ Ⓐ + _____ Ⓑ + _____ Ⓒ = _____ Total Tuition

Deposit 50% of Tuition or Pay in Full _____ + $35 Registration Fee = _____ TOTAL DUE

I, the parent/guardian of the above named student, hereby give permission to Barking Cat Studio, Inc., its agents, representatives, and employees, to enroll my child in all activities offered by Barking Cat Studio, Inc. Art in the City Camp Programs, including local full day field trips within New York City and the transportation required through public subway, bus or by bus company hired by Barking Cat Studio, Inc. as part of the regular Barking Cat Studio, Inc. Art in the City Day Camp program. In consideration of my child's participation in Barking Cat Studio, Inc. Art in the City Camp Program, I, the undersigned, waive all claims for damages I may have against Barking Cat Studio, Inc., its directors, officers, trustees, faculty, and employees for any and all injuries suffered by my child. I agree to release, indemnify, and hold harmless Barking Cat Studio, Inc., its summer camp program, its staff, agents and representatives from all claims of liability, injury or damage to any person occurring in connection with Barking Cat Studio activities. Barking Cat Studio has the unrestricted right to terminate this enrollment agreement at its sole discretion. In the event of such termination due to camper behavior, Barking Cat Studio is not obligated to refund tuition or any unused amount of tuition. I also give permission to Barking Cat Studio, Inc., if its staff is unable to contact me, to take any necessary steps to obtain proper treatment of my child in the event of a sudden illness or injury. I understand that every effort will be made to notify me immediately in case of such an emergency. I further agree to be totally and completely responsible for the payment of all debts, expenses, or bills incurred in connection with any illness or injury of my child. Barking Cat Studio, Inc. has permission to treat my child for routine, minor injuries such as scrapes and bruises. In the event that a parent, emergency contact or the family physician cannot be contacted in an emergency, Barking Cat Studio, Inc. has the permission to have my child examined at a hospital emergency room. Barking Cat Studio, Inc. has permission to reproduce and publish any photograph, video or likeness of my child for advertising, promotion, commercial or any lawful purpose. I acknowledge and agree that no compensation is being paid or will be paid for the making or use of these materials, and I waive all rights, interest, or claim for payment in connection therein.

Parent/guardian name (printed): _____ Date: _____

Signature: _____ Relation to child: _____

Barking Cat Studio ARTcamP

Child & Family Information

Date _____

1 Child's Name (last) _____ (first) _____ Preferred Pronoun ☐ She/Hers ☐ He/His ☐ They/Them ☐ Other

Date of Birth ___/___/___ Grade in September _____ School _____ Kid T-Shirt Size ☐ S ☐ M ☐ L ☐ XL

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2 Child's Name (last) _____ (first) _____ Preferred Pronoun ☐ She/Hers ☐ He/His ☐ They/Them ☐ Other

Date of Birth ___/___/___ Grade in September _____ School _____ Kid T-Shirt Size ☐ S ☐ M ☐ L ☐ XL

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3 Child's Name (last) _____ (first) _____ Preferred Pronoun ☐ She/Hers ☐ He/His ☐ They/Them ☐ Other

Date of Birth ___/___/___ Grade in September _____ School _____ Kid T-Shirt Size ☐ S ☐ M ☐ L ☐ XL

Main Parent to Contact (Parent 1): _____ Best number to reach you during camp hours: _____

Email Address Parent 1: _____ Email Address Parent 2: _____

Parent 2: _____ Best number to reach you during camp hours: _____

Address: _____ City: _____ State: _____ Zip: _____

Pick Up– Please list the names and phone numbers of the people who are approved to pick-up your child: _____

Name and relation of emergency contact: _____ Phone: _____

Does your child have an individual in their life that has a restraining order or similar order of no contact? If so, please provide additional information on that person. _____

Name of physician: _____ Phone: _____

Health condition(s) that staff should be aware of: _____

Activities in which your child should NOT participate: _____

Life-threatening allergies ☐ No ☐ Yes* (describe): _____

Operations or serious injuries (with dates): _____

Is your child under a doctor's care for an ongoing condition? ☐ No ☐ Yes (describe): _____

Any permanent disability or chronic or recurring illness ☐ No ☐ Yes (describe): _____

Does your child take any medication (prescribed or over-the-counter)? ☐ No ☐ Yes If yes, please provide reason, dosage, and frequency: _____

Is your child vaccinated against COVID19? ☐ Yes Proof of Vaccination required. ☐ No _____

Does your child require an Epi Pen? ☐ No ☐ Yes If yes, staff must be made aware and provided with an Epi Pen for your child on their first day of camp. _____

Date of last physical examination: _____ (Health Record form must be received by June 1)

**Please note that all children attending camp must have a physical examination within 12 months of attendance of camp and the Health Record form must be completed by a licensed physician.*

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly Press Hard

STUDENT ID NUMBER
OSIS

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | Sex ☐ Female ☐ Male | Date of Birth (Month/Day/Year) __ __ / __ __ / __ __ __ __

Child's Address | Hispanic/Latino? ☐ Yes ☐ No | Race (Check ALL that apply) ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other

City/Borough | State | Zip Code | School/Center/Camp Name | District Number __ __ __ | Phone Numbers: Home, Cell, Work

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ Parent/Guardian Last Name First Name ☐ Foster Parent

TO BE COMPLETED BY HEALTH CARE PROVIDER

If "yes" to any item, please explain (attach addendum, if needed)

Birth history (age 0-6 yrs)

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs (list) _____

☐ Foods (list) _____

☐ Other (list) _____

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma (check severity and attach MAF/Asthma Action Plan): ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteroid ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder ☐ Orthopedic injury/disability

☐ Chronic or recurrent otitis media ☐ Seizure disorder

☐ Congenital or acquired heart disorder ☐ Speech, hearing, or visual impairment

☐ Developmental/learning problem ☐ Tuberculosis (latent infection or disease)

☐ Diabetes (attach MAF) ☐ Other (specify) _____

Explain all checked items above or on addendum

Medications (attach MAF if in-school medication needed) ☐ None ☐ Yes (list below)

Dietary Restrictions ☐ None ☐ Yes (list below)

PHYSICAL EXAMINATION

Height _____ cm (___ ___ %ile)

Weight _____ kg (___ ___ %ile)

BMI _____ kg/m² (___ ___ %ile)

Head Circumference (age ≤2 yrs) _____ cm (___ ___ %ile)

Blood Pressure (age ≥3 yrs) _____ / _____

General Appearance:

	NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl
HEENT	☐	☐	Lymph nodes	☐	☐	Abdomen	☐	☐	Skin	☐	☐	Psychosocial Development	☐	☐
Dental	☐	☐	Lungs	☐	☐	Genitourinary	☐	☐	Neurological	☐	☐	Language	☐	☐
Neck	☐	☐	Cardiovascular	☐	☐	Extremities	☐	☐	Back/spine	☐	☐	Behavioral	☐	☐

Describe abnormalities:

DEVELOPMENTAL (age 0-6 yrs) ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive (e.g., play skills) _____

☐ Communication/Language _____

☐ Social/Emotional _____

☐ Adaptive/Self-Help _____

☐ Motor _____

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)	__ __ / __ __ / __ __	_____ µg/dL
	__ __ / __ __ / __ __	_____ µg/dL
Lead Risk Assessment (annually, age 6 mo-6 yrs)	__ __ / __ __ / __ __	☐ At risk (do BLL) ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	__ __ / __ __ / __ __	☐ Normal ☐ Abnormal
—— Head Start Only ——		
Hemoglobin or Hematocrit (age 9–12 mo)	__ __ / __ __ / __ __	_____ g/dL _____ %

	Date Done	Results
Tuberculosis	Only required for students entering intermediate/middle/junior or high s who have not previously attended any NYC public or private school	
PPD/Mantoux placed	__ __ / __ __ / __ __	Induration _____ mm
PPD/Mantoux read	__ __ / __ __ / __ __	☐ Neg ☐ Pos
Interferon Test	__ __ / __ __ / __ __	☐ Neg ☐ Pos
Chest x-ray (if PPD or Interferon positive)	__ __ / __ __ / __ __	☐ Nl ☐ Abnl ☐ Not Indicated
Vision (required for new school entrants and children age 4–7 yrs)	__ __ / __ __ / __ __ ☐ with glasses	Acuity Right ___ / ___ Left ___ / ___ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child

Hep B	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
Rotavirus	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
DTP/DTaP/DT	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
Hib	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
PCV	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
Polio	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __

Influenza	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	
MMR	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
Varicella	__ __ / __ __ / __ __	__ __ / __ __ / __ __		
Td	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
Tdap __ __ / __ __ / __ __	Hep A	__ __ / __ __ / __ __	__ __ / __ __ / __ __	
Meningococcal	__ __ / __ __ / __ __	__ __ / __ __ / __ __		
HPV	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	
Other, specify: _____	__ __ / __ __ / __ __ ;	_____	__ __ / __ __ / __ __	

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet

☐ Restrictions (specify) _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: __ / __ __ / __ __

Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other _____

ASSESSMENT ☐ Well Child (V20.2) ☐ Diagnoses/Problems (list) ICD-9 Code

_____ __ __ __ __

_____ __ __ __ __

_____ __ __ __ __

Health Care Provider Signature | Date __ __ / __ __ / __ __

Health Care Provider Name and Degree (print) | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (__ __ __) ___ ___ ___ – ___ ___ ___ ___ | Fax (__ __ __) ___ ___ ___ – ___ ___ ___ ___

DOHMH ONLY PROVIDER I.D.

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments

Date Reviewed: __ __ / __ __ / __ __ I.D. NUMBER

REVIEWER: